STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012131	A. BUILDING _____ B. WING _____	C 08/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF NORTHWESTERN INDIANA	9509 GEORGIA ST CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one State hospital complaint. Complaint Number: IN00106575 Unsubstantiated: Lack of Sufficient Evidence Date: 8/27/12 and 8/28/12 Facility Number: 012131 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Vibra Hospital of Northwestern Indiana is in compliance with 410 IAC 15-1.5-6, Nursing Services, Indiana Hospital Licensure Rules. QA: claughlin 09/07/12	S 000		